Mail to: New Hampshire Victims' Assistance Commission
Department of Justice
33 Capitol Street
Concord, N.H. 03301-6397

Questions? Call 1-800-300-4500 (*in NH only)*
or (603) 271-1284

DO NOT WRITE IN THIS SPACE
CLAIM # _____
DATE RECEIVED _____
COUNTY _____

Application Form

PLEASE TYPE OR PRINT CLEARLY **Each section of this application must be completed**

You are filing this application because you are *(check one)*

☐ 1 The victim of a crime
☐ 2 An immediate family member of a crime victim who died as a direct result of a crime
☐ 3 The parent/guardian of a crime victim under 18 years of age
☐ 4 The guardian of a crime victim who is incompetent
☐ 5 Other, explain: _____

SECTION 1. ELIGIBILITY CRITERIA

1. Did the crime occur in N.H.? ☐ Yes ☐ No
2. Did the crime result in personal injury (including mental trauma) or death? ☐ Yes ☐ No
3. Did the crime occur on or after November 2, 1989? ☐ Yes ☐ No
4. Did you report the crime to law enforcement within 5 days? ☐ Yes ☐ No If no, explain why not.

_____

_____

5. Did you file this claim within 1 year of the crime? ☐ Yes ☐ No If no, explain why not.

_____

6. Is your out-of-pocket loss or liability more than $100.00? ☐ Yes ☐ No

SECTION 2. VICTIM INFORMATION

Victim's Name _____ ☐ Male ☐ Female

ADDRESS - STREET CITY STATE ZIP CODE

MAILING ADDRESS, IF DIFFERENT CITY STATE ZIP CODE

Phone *(include area code)*
Work:
Home:

Social Security Number	Marital Status	Age of Victim on Date of Crime	Date of Birth
	☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed		MONTH DAY YEAR

Spouse's Name

Dependent's Names, Relationships and Ages

Victim's Occupation at Time of Crime	Victim's Employer and Employer's Address at Time of Crime
Victim's Current Occupation *(if different from above)*	Victim's Current Employer and Employer's Address

OPTIONAL – FOR FEDERAL GOVERNMENT REPORTING PURPOSES ONLY

National origin of Victim	Race of Victim	Disabilities of Victim *(if any)*

SECTION 3. CLAIMANT INFORMATION (If someone other than victim is filing claim)

Your Name	Relationship to Victim

Address - Street City State Zip Code

Phone *(include area codes)*
Work:
Home:

Social Security Number	Marital Status	Date of Birth
	☐ Single ☐ Widowed ☐ Divorced ☐ Married ☐ Separated	MONTH DAY YEAR

Claimant's Occupation	Claimant's Employer and Employer's Address

SECTION 4. TOTAL (Must be completed)

Type of compensation you are requesting:

Money for Medical expenses $ _____ Money for Funeral expenses $ _____

Money for Lost income $ _____ Money for Mental Health Counseling Expenses $ _____

Other (provide documentation) $ _____ TOTAL COMPENSATION $ _____

(If you are still receiving services and/or have not received all of your bills, please place a plus (+) symbol after each amount that may increase.)

SECTION 5. CRIME, INJURIES AND RELATED INFORMATION

Date of injury to victim (if exact date(s) is unknown, indicate the approximate time frame of victimization)	Date of death of victim	Where did injury occur
MONTH DAY YEAR	MONTH DAY YEAR	CITY COUNTY STATE

Brief description of crime and injuries (including mental health trauma) resulting from crime

(if necessary, use additional pages)

Name of Offender(s)
(Necessary if known)

Name of law enforcement agency reported to	Phone No. & Ext.	Date and time reported

Name of Investigating Officer(s)

Has arrest been made? ☐ Yes ☐ No

Has offender been charged in court? ☐ Yes ☐ No If yes, what are the charges? _____

Did victim know the offender? ☐ Yes ☐ No If yes, in what way? _____

Was the victim related to offender? ☐ Yes ☐ No If yes, in what way? _____

Was victim living in same house as offender at the time of the crime? ☐ Yes ☐ No

If yes, is victim still living in same house as offender? ☐ Yes ☐ No

Has prosecution begun? ☐ Yes ☐ No Court Case # _____ County _____

Name of Prosecuting Attorney _____ Name of Victim/Witness Advocate _____

SECTION 6. INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION:

IF ANY OF THE VICTIM/CLAIMANT'S CRIME-RELATED EXPENSES CLAIMED IN SECTION 4 OF THIS APPLICATION MAY BE FULLY OR PARTIALLY COVERED BY ANY PUBLIC OR COMMERCIAL HEALTH, DISABILITY, LIFE, AUTOMOBILE, HOMEOWNER'S OR OTHER INSURANCE; THE HOSPITAL'S FREE-CARE PROGRAM; WORKER'S OR UNEMPLOYMENT COMPENSATION; SICK, VACATION OR PERSONAL LEAVE; UNION OR FRATERNAL BENEFITS; PENSIONS OR RETIREMENT FUNDS; RESTITUTION; CIVIL SUIT JUDGEMENTS OR ANY OTHER RESOURCE; PLEASE EXPLAIN IN FULL ON A SEPARATE PIECE OF PAPER AND ATTACH IT TO THIS APPLICATION. INCLUDE THE COMPLETE NAMES, ADDRESSES AND PHONE NUMBERS OF YOUR RESOURCES AND OF YOUR PRIVATE ATTORNEY, IF ANY. IF YOU DO NOT HAVE ANY RESOURCES TO ASSIST YOU, AND YOU HAVE APPLIED FOR ASSISTANCE FROM MEDICAID, MEDICARE, THE FREE-CARE PROGRAM AT THE HOSPITAL AND ANY OTHER PUBLIC ASSISTANCE PROGRAM, BUT WERE DETERMINED TO BE INELIGIBLE, ATTACH COPIES OF THE DOCUMENTS THAT SHOW YOUR INELIGIBILITY FOR PUBLIC ASSISTANCE AND SIGN THE STATEMENT BELOW:

I DECLARE, UNDER PENALTY OF PERJURY, THAT THE EXPENSES AND LOSSES CLAIMED IN SECTION 4 HAVE NOT, WILL NOT AND CAN NOT BE COVERED BY ANY OTHER RESOURCE OR PUBLIC ASSISTANCE PROGRAM.

DATE _____ **VICTIM/CLAIMANT'S SIGNATURE X** _____

SECTION 7. Both Sections Below Must Be Completed and Signed

AUTHORIZATION: I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO ATTENDED OR EXAMINED (NAME OF VICTIM) _____ : ANY FUNERAL DIRECTOR OR OTHER PERSON WHO RENDERED SERVICES, ANY EMPLOYER OF THE VICTIM; ANY POLICE OR OTHER LOCAL GOVERNMENTAL AGENCY, INCLUDING STATE AND FEDERAL REVENUE SERVICES; ANY INSURANCE COMPANY, OR ORGANIZATION HAVING KNOWLEDGE, TO FURNISH TO THE NH VICTIMS' ASSISTANCE COMMISSION, OR ITS REPRESENTATIVE, ANY AND ALL INFORMATION WITH RESPECT TO THE INCIDENT LEADING TO THE VICTIM'S PERSONAL INJURY OR DEATH, AND THE CLAIM MADE HEREWITH FOR COMPENSATION. A PHOTOCOPY OF THIS AUTHORIZATION IS AS EFFECTIVE AND VALID AS THE ORIGINAL.

DATE _____ **VICTIM/CLAIMANT'S SIGNATURE X** _____

DECLARATION: I UNDERSTAND THAT ANY RECOVERY OF MY LOSSES THROUGH LEGAL ACTION SHALL ENTITLE THE STATE OF NEW HAMPSHIRE TO REIMBURSEMENT TO THE EXTENT OF ANY COMPENSATION AWARDED ME. I ALSO UNDERSTAND THAT MY PROVIDERS MAY BE REIMBURSED DIRECTLY FOR DEBTS THAT I OWE. I DECLARE, UNDER PENALTY OF PERJURY, THAT I HAVE READ ALL THE QUESTIONS IN THE CLAIM FORM AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY ANSWERS ARE TRUE, CORRECT AND COMPLETE.

DATE _____ **VICTIM/CLAIMANT'S SIGNATURE X** _____

You may be requested to submit further information to the Victims' Assistance Commission after your application has been received. Please be aware that it takes an average of 60 days, after all pertinent information has been furnished to the commission, before a decision on your application is made. If you would like to submit copies of your bills for expenses that are directly related to the crime at this time, please feel free to do so. If you have any questions about this application form or the NH Victims' Assistance Commission, please call (603) 271-1284 or 1-800-300-4500 (in the State of New Hampshire only).